TULARE COUNTY

MEDICAL CERTIFICATION – EMPLOYEE'S FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For completion by the EMPLOYEE

Employee's Name:_____ Contact Phone While on Leave:_____

Employee's Department: _____ Title: _____

Patient's Name:_____ Relationship to EE:_____

Describe the care you will provide to family member and provide an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

_____

_____

_____

Employee Signature: _____ Date: _____

SECTION II: For completion by the HEALTH CARE PROVIDER

Does the employee's child, parent, spouse, or domestic partner have an illness, injury, impairment, or physical or mental condition which constitutes a "serious health condition."? Types of serious health conditions are attached (see last page). Does the patient's condition qualify under any of the categories described? If yes, please list the category._____ If 'serious health condition' is related to pregnancy please list the estimated due date: _____ _____
If the "serious health condition" does not fall into one of these categories please describe the medical facts pertaining to the need for employee to take a leave of absence (do not include genetic information*):

_____

_____

_____

2. Date medical condition or need for treatment commenced:_____

3. Probable duration of medical condition or need for treatment:_____

4. Please answer the following:

Yes	No	
❑	❑	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
Yes	No	
❑	❑	After review of the employee's signed statement of care above, does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

5. Estimate the period of time, care, or presence by the employee is needed. Please specify return to work date.

_____

6. Please answer the following question only if the <u>intermittent</u> leave or a reduced work schedule is needed.

Yes	No	
❑	❑	Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee's family member? If the above answer is yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider.

_____

_____

_____

Signature of Health Care Provider: _____ Date: _____

Health care Provider Address: _____

Health Care Provider Telephone:_____FAX:_____

Please return this form to _____ (Name/Department)

Phone/FAX _____

*"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Serious Health Conditions
Defined by the Family Medical Leave Act

__ ***Hospital Care***

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

__ ***Absence Plus Treatment***

(a) A period of incapacity of more than three consecutive, full calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2)Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (e.g., prescription medication or therapy with specialized equipment but not over-the-counter medications or salves, bed rest, fluid intake, or exercise.) under the supervision of the health care provider. The in-person treatment visit must take place within seven days of the first day of incapacity. *****

NOTE: As the accepted practice of the County, the leave process is triggered by an absence of 40 hours or more. While the Absence Plus Treatment scenario is FMLA qualified and only three days in duration, the County practice of using 40+ hours as a benchmark to start the LOA process will continue to be followed. However; there may be cases in which an employee will qualify for FMLA under Absence Plus Treatment with out meeting the 40+ hours as stated in the personnel rule. In these cases, FMLA should be designated to comply with the Act.

__ ***Pregnancy***

Any period of incapacity due to pregnancy, or for prenatal care.

__ ***Chronic Conditions Requiring Treatments***

A chronic condition which:

(a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

__ ***Permanent/Long-term Conditions Requiring Supervision***

A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

__ ***Multiple Treatments (Non-Chronic Conditions)***

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of healthcare services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three full consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).